

**AB 2170 (B. Lowenthal)**  
Continuity of Care for Prescription Drug Coverage  
Fact Sheet

**SUMMARY**

This bill would prohibit group health plans regulated by the Department of Managed Health Care and group health insurance policies regulated by the Department of Insurance from increasing their enrollees' out-of-pocket costs for their prescription drugs during the contract year. AB 2170 will protect individuals enrolled in group health insurance plans and group health insurance policies from sudden and unplanned out-of-pocket costs for their prescription medications.

**BACKGROUND**

Prescription drugs are one of the fastest growing health care costs in the U.S. Many health care consumers, including those with good insurance plans, are subject to state law and health insurer' rules that allow changes in co-payments for covered prescription drugs during the enrollment year. These increases are due to changes made by health insurance plans in their prescription drug tier assignments.

Insurers generally use multi-tiered systems of prescription drug coverage. A tiered formulary divides a health plan's formulary of drugs into categories and assigns a different co-payment to each tier. The tiers are designed to encourage use of the least expensive medication. Most health insurers divide their drug formulary into 3 or 4 tiers. Each tier is assigned a different co-payment. Typically,

- **Tier 1** is for generic drugs, which usually has the lowest co-payment.
- **Tier 2** is for preferred brand name drugs with a somewhat higher co-payment.
- **Tier 3** is for non-preferred brand name or off-formulary drugs with the highest co-payment.
- **Tier 4**, used by about 30% of insurers, is for high cost specialty drugs used to treat serious chronic diseases such as multiple sclerosis, HIV/AIDS, rheumatoid arthritis, hepatitis C, cancer and others. Insurers charge a percentage of the drug cost, usually 20% to 33%.

Currently, health insurers are allowed to move a brand name medication from a lower tier to a higher tier at any time during the contract year. Their decision is based on a number of factors, including the loss of patent protection for a medication, how health insurers see demand for a drug, or price negotiations with pharmaceutical companies for preferred drug status. The result, however, can be a steep increase in the enrollee's co-payment.

**NEED FOR LEGISLATION**

For consumers of prescription medications and particularly for people with chronic conditions who may use multiple medications, the insurer's drug formulary and the amount of the co-payment to be paid by enrollees plays a significant part in their selection of a health insurance plan during the open enrollment period. Knowing what their co-payments will be for their prescription drugs allows enrollees to calculate and budget for their annual out-of-pocket costs. Consequently, consumers are surprised, confused and often times unprepared when, during the contract year, their out-of-pocket costs for prescription medications increase. Oftentimes, enrollees discover the change in out-of-pocket costs when refilling the prescription at the pharmacy. Those who cannot afford to pay the increased cost may be forced to go without essential medications or switch to a different medication for reasons having nothing to do with their health.

**THIS BILL**

To ensure continuity of care and protect consumers from unplanned increases in out-of-pocket costs for prescription medications, the proposed legislation prevents group health insurers from increasing enrollees' out-of-pocket costs for their prescription drugs between annual open enrollment periods.

**SUPPORT**

National MS Society- CA Action Network (Sponsor)

**OPPOSITION**

None at this time.

**FOR MORE INFORMATION**

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